B5050-7 A

Lifecare Industry-1984

Laventhol & Horwath
Certified Public Accountants

1984 Edition

4TH ANNUAL REPORT ON THE LIFECARE INDUSTRY IN THE UNITED STATES

LIFECARE INDUSTRY

2	**An Introduction to Lifecare Industry 1984** by James F. Sherman
3	**Comments From Around the Country**
5	**The Trend Toward An Intermediate Level of Care** by Donald Dahlfues
5	**A Successful Formula for Survival in the Lifecare Industry** by James M. Draper
6	**The Proprietary Lifecare Community Comes of Age** by Susan Brecht and Michael J. Fogel
8	**The Lifecare Industry—1984**
8	**Introduction**
9	**Profile of Participants**
10	**Acreage**
10	**Area of Facilities**
10	**Nursing Center Beds**
11	**Marketing Results**
12	**Apartment Entrance Fees**
14	**Monthly Apartment Fees**
16	**Nursing center rates**
16	**Rate Increases**
17	**Patient Days in the Nursing Center**
17	**Average Age of Residents**
18	**Financial Assistance Plus Selected Information**
19	**Percentage of Males and Females**
19	**Apartment Turnover Rates**
20	**Payroll and Employee Information**
22	**Payroll and Employee Ratios**
24	**Various Expense Ratios**
24	**Loss of Revenue**
24	**Reserve Funds**

© 1984

Laventhol & Horwath
Certified Public Accountants

Executive Offices: 1845 Walnut St., Philadelphia, PA 19103 • (215) 299-1600
$35 per copy

AN INTRODUCTION TO LIFECARE INDUSTRY 1984

by James F. Sherman

The retirement center industry experienced dynamic growth during 1983 and the first quarter of 1984. A variety of new retirement centers, including congregate residential communities, lifecare facilities and modified versions of both, are being developed, constructed and opened throughout the country.

Because this market is so diverse, no single type of facility is leading the others in rate of construction. It would be impossible to estimate the number of new facilities being considered, but it is safe to speculate that they are being proposed in almost every city and small town to meet the needs of the country's growing elderly population.

A surge in development

The outlook for future development, at least until the year 2035, resembles the gold rush of the past. Why 2035? That is the year when the aging of America is projected to level off. Until then, the size of the elderly population is expected to increase both in number and as a percentage of the total population.

During the past year an interesting phenomenon occurred. For the first time, leaders of major corporations began to explore the benefits of developing retirement centers. Hospital and nursing home administrators also displayed new interest. These different entities could share services, with facilities serving as feeders for each other.

New sites

College and university officials represent another segment of society interested in developing retirement centers. A retirement center initially may not appear compatible with a college or university's goals, but professors as well as alumni from various institutions are requesting to live near their school when they retire.

Residents of a college- or university-sponsored retirement facility could attend classes of interest, or offer tutorial services. An appropriately structured program could even provide a mechanism to increase the school's endowment funds. Proposals for the development of college- or university-affiliated retirement centers should increase as the concept becomes more popular.

Religious organizations have continued to be active in developing retirement centers. A new thrust from hospitals with a religious affiliation was apparent in 1983. Operators of one hospital group plan to build retirement centers throughout the country, on or near their hospitals' premises. Nursing home operators continue to expand their facilities to include independent living units.

Nationwide growth

An analysis of several markets indicates a promising future in small cities as well as in major metropolitan areas.

Just as the types of projects being considered and their developers vary, so do the kinds of financing methods and organizational and fee structures established for these facilities. At L&H we have developed organizational structures based on a limited partnership owning the depreciable property and leasing it to the nonprofit corporation, which operates the facility and receives the resident entry fees. These entrance fees provide some or all of the permanent mortgage financing for the project. Such a structure allows the nonprofit corporation to maintain the lowest possible monthly rates because the residents are providing mortgage funds themselves instead of paying market interest rates. Entrance fees can also be lower because the limited partners will invest substantial funds to cover project costs.

Many proprietary organizations are developing rental-only centers, while nonprofit sponsors continue to use entrance fees. Monthly fees are determined by the extent of entrance fees charged as well as the service package offered to residents. Customarily, fewer services are provided in rental facilities compared with the broader base of services offered in facilities that require both an entrance and monthly fee.

Refunding fees

The "unbundling" of health care services continued during 1983, allowing residents to pay for only the health care services they use. In addition, the policy of refundable entrance fees is gaining in popularity. Generally, between 50 and 100 percent of the original entrance fee is refunded. Refunds usually are made when the resident permanently transfers out of his apartment and the apartment is resold. In some cases, the refundable portion of the entrance fee may be held in trust for the resident with income, or even principal, applied to the resident's long-term health care costs.

As the lifecare industry expands, the ideas for developing various projects will continue to be refined. It is only beginning. ■

James F. Sherman, CPA, is a partner in Laventhol & Horwath's Executive Offices, Philadelphia, and L&H's National Director, Public Finance and Health Care Consulting.

COMMENTS FROM AROUND THE COUNTRY

From Cleveland

Scattered interest in lifecare communities has been generated in Ohio primarily by owners of nursing home chains who already are knowledgeable about and experienced in the health care industry.

Ideas for the future include developing lifecare facilities on land adjacent to existing nursing homes, thereby establishing feeders for nursing homes; building new retirement center/nursing home combinations in areas of the Sunbelt, and creating retirement-only facilities (e.g., in a resort community) where some health care amenities are provided but not emphasized.

Several local nonprofit organizations also are considering involvement in the lifecare industry. Some have already conducted marketing studies, with positive results, and are now examining residence mix, absorption rate and other key factors. The results of feasibility studies prepared for small population centers have been negative, primarily due to insufficient market demand.

Although both proprietary and nonprofit organizations in the area are entering the lifecare industry, they are still in the planning stage. Therefore, certain specific issues, such as refundable entry fees and financing methods, have not yet been resolved.

A task force appointed by the director of the state's Department of Health has developed a draft of Certificate of Need (CON) Criteria for Long-Term Care Facilities, which recognizes the increasing importance of lifecare. The draft, dated March 8, 1984, suggests that when CON applications are judged, "preference be given to 'residential communities' where a minimum of four independent living units for each long-term care bed is proposed" and "applications shall be for no less than 100 beds. Consideration will be given to 50-bed proposals in some unusual areas or when part of the 'retirement community'."

Charles C. Rosenbaum
Cleveland

From Los Angeles

Lifecare communities anticipated in the Los Angeles area include:

- A continuing care retirement center (CCRC) under construction in Rancho Bernardo, with 146 independent living units and 59 skilled nursing beds. The entrance fee is partially refundable and the residents pay for health care as needed.
- A joint venture between a medical center parent corporation and a developer, in Laguna Hill. This facility, which is being developed as a for-profit entity with no entrance fee, will have 210 independent living units, including 28 personal care beds and 162 skilled nursing beds (50 of which are distinct part rehabilitation).
- Two potential projects in Poway, both planned as for-profit, adult congregate living facilities (ACLFs) with a month-to-month rental charge and no health care amenities. One will contain 99 independent living units, the other between 120 and 135.

Jerry T. Quigg
Los Angeles

From Philadelphia

Philadelphia, the City of Brotherly Love, loves lifecare. So does the Greater Delaware Valley, comprising parts of Eastern Pennsylvania, Delaware and southern New Jersey. Within 35 miles of the statue of William Penn atop Philadelphia's City Hall is the greatest concentration of CCRCs in the world.

Twenty-seven facilities are in operation with a total of 6,622 apartments and 2,372 nursing beds or personal care units. The newest one, a 24-story gleaming white tower, which opened in 1984 is located less than half a mile from City Hall to satisfy center city residents who want to remain in the center of Philadelphia's cultural and social environment. The primary market area penetration of the eligible elderly population ranges from 8 to 20 percent, a popularity for retirement centers that surprises even their most enthusiastic advocates.

Entrance fees to the facilities range from $15,200 to $160,000. Except for the newest one, which has a full refund policy, the amounts paid in revert to the communities during a fixed period of years. Many of the facilities have a religious affiliation and almost all operate as nonprofit entities.

Is the expansion boom over? Hardly! Prospective facilities in Main Line locations are being actively promoted, and others are in the discussion stage. Several are being planned for southern New Jersey, still relatively virgin territory for lifecare communities. Additional communities in Delaware also are being considered.

However, some areas may have too many facilities. For example, a new community in Northeast Philadelphia never opened its doors to residents and defaulted on a $33 million tax-free bond issue. Another retirement center, outside the city limits, has less than 60 percent occupancy and is in default of its bond issue. A few other facilities have been slow in filling their space and are solving their difficulties in various ways.

The general opinion is that lifecare communities in the Philadelphia area are more than fulfilling the promises made to residents during the marketing phase. Most of these communities have long waiting lists.

M. Stroud Curran
Philadelphia

From St. Louis

The increase in the number of elderly people in the St. Louis metropolitan area has generated an increase in the number of retirement facilities. In St. Louis and St. Charles Counties alone, there is a total of 1,886 units in CCRCs and ACLFs.

Real estate developers, nursing home operators, hospital administrators and

leaders of religious organizations all recognized the potential influence retired people would have on the local economy. Because the percentage of elderly people in the St. Louis area is expected to increase, seven CCRCs were developed during the past eight years.

However, statewide legislation enacted in June 1983 has prevented the development of additional CCRCs. The law has placed a four-year moratorium on issuing CONs for construction of long-term care beds. As a result, no new nursing care beds will be constructed in Missouri until June 1987.

On the other hand, the number of ACLFs in the St. Louis area has increased. Three have opened since 1979, and another is currently under construction and scheduled to open in early 1985.

As the economy continues to improve and the number of elderly people increases, the prospect for future development of ACLFs in St. Louis appears to be strong.

Steven R. Marmurek
St. Louis

From San Francisco

Several lifecare communities are planned or under construction in the San Francisco area.

A 224-unit facility in San Rafael is near completion and scheduled to open in early 1985. This project was conceived by a medical doctor, who serves as a general partner and has several limited partners.

Because residents own their unit (entry fees range from $139,000 to $414,000), the facility may not qualify technically as a lifecare community. Monthly fees will be assessed to cover a comprehensive list of amenities including unlimited use of the 40-bed skilled nursing center. As a result of marketing efforts conducted for more than a year, between 70 and 75 percent of the units have been presold.

Another project currently being developed in San Rafael has been temporarily delayed by zoning concerns. This 400-unit luxury lifecare facility also was conceived by a medical doctor who acts as a general partner with several limited partners.

The entry fee is partially refundable, and the monthly service fee will cover basic amenities and 30-day annual noncumulative care in the personal care or skilled nursing facility. The first phase of this project is scheduled for completion in early 1986.

A lifecare community under construction in Santa Rosa is expected to open in late 1985. This 350-unit facility will be owned and operated by a nonprofit, church-affiliated foundation. The entry fee is refundable over a 67-month period, and monthly fees will be assessed to cover amenities such as unlimited, on-site physician services, acute care, skilled nursing and personal care services. Following a recently begun marketing program, deposits have been secured for 100 units.

Additional lifecare communities being considered in the San Francisco area include two facilities based on proprietary ownership and one nonprofit operation.

David S. Kornblum
Patrick E. Carroll
San Francisco

From Southern Florida

The market for lifecare communities in Southern Florida continues to be active. Developers are examining rental ACLFs as well as CCRCs, with twice as many rental projects being considered. Most of the projects recently proposed or under construction will be operated on a for-profit basis.

A trend is emerging among area CCRCs to refund a portion (usually between 50 and 75 percent) of the entrance fee. There also is an increasing demand for personal care/assisted living units and beds.

Although many developers continue to enter this exciting industry, there still is room to expand the market for retirement communities. Successfully marketed CCRCs are experiencing between 8 and 10 presales per month. Operators of some recently completed projects report a monthly move in/absorption rate of between 20 and 30 units.

As in the past, the key to successful CCRCs and rental ACLFs is to combine an effective marketing program with knowledgeable management.

Donald M. Dahlfues
Miami

From Western Florida

Activity in the lifecare industry in the western and central areas of Florida has been strong despite recent state legislation affecting retirement facilities with entrance fees. Presale and escrow requirements currently in effect have not slowed developers' interest in the market.

The trend, particularly in newer facilities, is toward higher entrance fees (many partially refundable) and lower monthly maintenance fees. Rental ACLFs also are gaining in popularity as many developers are considering alternative projects to avoid compliance with the new legislative guidelines. Garden-style apartments are replacing the older, institutional-type structures.

Most of the existing facilities in this part of the state are nonprofit with a religious affiliation. The newer operations are being developed primarily by nursing home or lifecare chains, or real estate developers. Operators of many existing facilities report occupancy rates of more than 95 percent, and many have extensive waiting lists.

Health care services provided at most facilities include emergency call systems and 24-hour nursing stations in addition to those facilities with on-site nursing or health centers. Generally, once a person becomes a permanent resident of a lifecare facility's health center, his or her monthly maintenance fee is replaced by a daily or monthly nursing charge.

The outlook for the lifecare industry in western and central Florida is favorable, as the new legal requirements are expected to improve the industry's image and credibility in the eyes of potential elderly residents.

Jane E. Zuknick
Tampa

THE TREND TOWARD AN INTERMEDIATE LEVEL OF CARE

by Donald M. Dahlfues

Historically, most lifecare/continuing care communities in the United States were developed to include an on-site nursing home, often referred to as the "health center." As part of the lifecare concept, this was and still is an important ingredient for developing a successful community since it allows residents to move easily from the living units to the health center when necessary.

Although this arrangement works well, can it be improved to provide a more appropriate level of care for residents who can no longer live independently in residential units, but do not require the nursing care offered in the health center? In response to this need, a new ingredient to the lifecare concept has been developed.

A logical concept

Personal care, or assisted living units, is a natural addition to the total lifecare concept. These assisted living units offer a level of care that falls between the health center and the residential units and can be operated at a lower cost per day than health center care. In a health center, operating costs of $40 to $50 per person per day are not uncommon; however, in assisted living units, operating costs are approximately $15 to $20 person per day. The difference in the bottom line is obvious.

But what is assisted living? It is providing assistance to elderly residents for such things as bathing, personal hygiene, dressing, eating, personal transportation (to and from dining and activities) and administration of medication. Common characteristics of assisted living units include no kitchens, since three meals a day are generally provided, either in the unit or in a dining room separate from the residents of the independent residential units. Also, single occupancy units are small—often, from 200 to 250 square feet—and have separate baths.

For residents only

In Florida, the ability to include health center beds in new lifecare communities is restricted by current Certificate of Need (CON) regulations. Health center beds can be provided, however, if they are only made available for use to residents of the community. These are called sheltered beds, and CONs can be obtained for one sheltered bed for every four residential units. The need for these health center beds generally increases as the lifecare community matures. During the first seven to ten years of new communities, many of these sheltered beds will remain empty. A natural alternative to allowing these rooms to go unused is to convert them to assisted living units temporarily. Thus, revenue can be generated to cover debt service on the cost of the health center beds until they are needed by the maturing lifecare community.

Assisted living units are becoming a noticeable trend in the lifecare industry. They provide a needed service for elderly people seeking an intermediate life style between independent residential units and skilled nursing homes. At the same time, lifecare communities can benefit from their low operating costs (compared with those for health centers) as well as from the additional revenue they generate as an alternative to empty health center beds in new communities. ■

Donald M. Dalfues, CPA, is a manager in the Management Advisory Services Department of Laventhol & Horwath's Miami office. He is the firm's Industry Director for Health Care in Florida.

A SUCCESSFUL FORMULA FOR SURVIVAL IN THE LIFECARE INDUSTRY

by James M. Draper

In recent months, two lifecare communities in the Philadelphia area filed for bankruptcy. Fiddler's Woods was substantially completed but was unable to open because a sufficient number of residents could not be obtained. Baptist Estates was partially occupied, but the occupancy level could not cover operating expenses and debt service. Both of these failures were well publicized because of their impact on residents, potential residents and bondholders. Current residents became concerned about who would assume responsibility for future operation of the facility; prospective residents were worried about their deposits; and bondholders experienced a sharp drop in the market value of their bonds. Failures in the lifecare industry have a ripple effect on other healthy communities. Residents become apprehensive and question the financial stability of their communities.

While Fiddler's Woods and Baptist Estates were having their difficulties, another company in the same market area was not only expanding its existing facilities, but also planning and constructing new communities. Waiting lists at the existing facilities could very easily have filled Fiddler's Woods and Baptist Estates. The story of this organization's success is enlightening, particularly since much of its success was accomplished in the Philadelphia area.

Concern prompts action

In 1971, Richard S. Coons, the pastor of

James M. Draper, CPA, is an audit partner who serves as Director of Accounting and Auditing in Laventhol & Horwath's Philadelphia office.

a small church in suburban Philadelphia, became concerned over the lack of adequate retirement facilities for the elderly members of his congregation. He and other members of the congregation formed a nonprofit 501(c)3 corporation to construct a 108-apartment retirement community on land adjacent to the church. The community was completed in 1972 and, surprisingly, all of the units were reserved prior to construction.

It was obvious that the need for middle-income retirement living was far greater than Coons had envisioned. An additional 165 residential units were constructed in 1976 within two miles of the original community. Once again, all of the units were reserved well before completion of the projects, and the waiting list began to grow rapidly.

Management company formed

Reverend Coons reevaluated his own calling and decided that he could serve society better by developing lifecare communities to care for the rapidly growing number of elderly people. He resigned his pastorate and formed a management company, Total Care Systems, Inc. (TCS), to develop and manage lifecare communities, which would be owned by the nonprofit corporation Adult Communities Total Services (ACTS).

TCS plans, designs, markets and manages all of the ACTS communities. Tight controls over construction costs, excellent design and the absence of unnecessary frills have resulted in many attractive, efficient communities that operate at a cost per unit far below industry averages. Buildings are relatively maintenance free.

In 1978, the two original communities were supplemented by Spring House Estates, a 328-apartment community constructed within one mile of the organization's second community. Southampton Estates with 377 units, and Lima Estates, with 300 units, were completed in 1980, giving ACTS 1,278 apartments in suburban Philadelphia. Concurrently with this local expansion, St. Andrews Estates in Boca Raton, Florida was constructed in two segments of 284 and 320 apartments. "ACTS South," as it was sometimes called, was further expanded by the addition of Edgewater Pointe Estates, a 360-unit community also in Boca Raton. Normandy Farms, a partially completed community in Blue Bell, Pennsylvania, will increase the northern communities to 1,638 units for a total of 2,602 nationally, with 422 nursing care beds. Two additional communities are in the planning stages because all of the existing communities are fully occupied. As of December 31, 1983, the assets of ACTS, Inc. exceeded $100 million.

Low debt service

The most significant aspect of the success of the ACTS communities has been the method of financing. Keeping construction costs low while charging entrance fees that are comparable to its competition, ACTS has been able to use the cash from these fees to cover a large portion of construction costs. The balance, approximately 15 percent, has been financed by conventional means, thereby avoiding the high cost of bond financing. The result is an extremely low debt service that equates to lower monthly maintenance fees for residents.

Because management is centralized through TCS rather than having duplication of efforts at each individual community, the management company has the resources to attract a higher level of talent and can use this talent over a broader base. Centralized purchasing and dietary departments allow for quantity pricing and uniformity in the quality of services among the various communities. The combination of all of these factors coupled with tight nursing controls, enables ACTS to charge its residents monthly fees that are 33 to 50 percent lower than comparable facilities.

A dedicated management team

Perhaps because of his ministerial background, Coons has been able to attract a truly dedicated management team of people who appreciate the concerns and needs of retirees. Many of these are "home grown," having been trained and developed internally.

The manner in which TCS has opened new communities has almost ensured its success; the company delays construction until a substantial portion of the units in the first phase are sold. Because of the success of the early projects and the uniformity of the communities, TCS is able to present existing communities to potential residents as examples of what life in a new retirement community will be like—even in terms of having them sample a typical meal. It is no secret that the greatest sales force in the lifecare industry consists of satisfied residents. The TCS sales force now exceeds 3,000. ■

THE PROPRIETARY LIFECARE COMMUNITY COMES OF AGE

by Susan Brecht and Michael J. Fogel

Throughout its relatively brief history, the American lifecare—or continuing care retirement community (CCRC)—industry has been dominated by communities that are owned and operated by nonprofit organizations. There are many reasons for this pattern, the main one being that the earliest CCRCs were developed by religious groups for their retiring clergy. This relationship grew stronger as many religious groups and other nonprofit organizations recognized how compatible the underlying precepts of CCRCs were with their missions.

During the past 10 to 15 years, the number of CCRCs has grown large enough to be considered a significant sector of the alternative housing market for the elderly. A major factor in the growth of this industry is the widely

Susan B. Brecht is an associate in Laventhol & Horwath's Philadelphia office. A member of the firm's Management Advisory Services Department, she specializes in the areas of lifecare and real estate.

Michael J. Fogel, CPA, J.D., LL.M, is a partner in the tax department of Laventhol & Horwath's Philadelphia office. He specializes in real estate equity syndications and is a frequent lecturer on real estate and tax shelters.

publicized dramatic increase in the size of the nation's elderly population. This demographic change has captured the attention of many organizations and institutions that previously had not focused on the elderly as a major market segment.

Growth assured

The growth in this segment of the population is projected to continue well into the 21st century. The Census Bureau predicts that not only will the number of people over the age of 65 *double* by the year 2025, but, equally significant, their income will increase at a faster rate than that of younger generations.

A natural result of this trend has been the increasing interest in participating in the lifecare industry from the for-profit sector. There has been some success in creating working relationships between nonprofit groups, development entities and investor partnerships in the development and operation of lifecare communities. In the best cases, these new relationships combine the talents and funds of the groups to provide the traditional environment of care in an organizational setting. At the same time, these cooperative efforts recognize that a lifecare community is also a business, which if properly managed will assure its residents greater security.

When for-profit organizations join forces with nonprofit groups, they have the opportunity to take advantage of the substantial tax benefits that accompany these large-scale, highly leveraged real estate transactions—benefits that previously were not available to them.

The tax burden

Notwithstanding the possibility of reductions in the depreciation allowances provided by the tax laws, the time has probably come for the development of totally proprietary lifecare communities, including entrance payments from residents. The problem to date with this approach has been the overwhelming tax burden on income received as entrance fees. A typical taxable community of 250 units, charging entrance fees averaging $50,000, could receive approximately $12,500,000 in taxable income over an 18- to 24-month period of time.

While the entrance fee concept has dominated the industry, some projects have been as structured as rentals—an approach that seems more compatible with the needs of a for-profit organization. The problem with no entrance fees is that high rents must be charged to cover the debt service as well as the extensive package of services and amenities that usually comprise the lifecare concept.

Research conducted by Laventhol & Horwath into the problems and issues facing proprietary lifecare communities has led to some recommendations about how to achieve the desired tax result.

Residents and owners benefit

The first recommendation is to structure entrance payments as debt instruments, such as mortgage equity bonds with a bank serving as trustee. This should give the payments the characteristics of loans from the residents to the owners of the CCRC. This structure, while relatively complex, has several advantages. Certainly, the greatest advantage for the owners is the probability of being able to treat the funds received as debt rather than taxable income. For the community residents who purchase the bonds, two major advantages are apparent. First, the mortgage bond serves as collateral that their entrance fees will be totally refunded. In addition, as compared with a rental project with a large mortgage, debt service on the project will be greatly reduced by using the entrance fee to repay all or most of the construction loan, and this will result in lower net monthly maintenance fees for the community's residents. The potential for the developer to syndicate such a project to limited partner investors is attractive because equity bonds provide most of the money required, and other sources of financing, such as conventional mortgages, are still available.

The tax-oriented syndication may be formed to own the depreciable property and lease to a for-profit operating entity or it could choose to participate in the entire venture. The appropriate structure depends upon the objectives of the developer and the potential economic and tax benefits of the particular venture. The availability of sophisticated computer modeling software makes it possible to explore the potential results of complex variations.

The matter of interest

The use of equity bonds in this fashion raises the question of whether the bonds must bear interest. Since the issue is controversial, we recommend the inclusion of interest unless an aggressive tax posture is acceptable to the investors and the residents. Recently proposed legislation, if passed, may rule out noninterest-bearing loans. The taxability of interest to the resident, while not a positive feature, should not cause significant problems for residents in low tax brackets.

Before a CCRC implements this approach to entrance fees, it should seek guidance from an attorney qualified in the Federal securities laws relating to the sale of bonds.

Opening the lifecare industry to the for-profit sector carries the promise and potential of a new and exciting array of resources in caring for the elderly. Finding creative ways to improve the lifecare concept is increasingly important as this country's elderly become a more dominant segment of the population. ■

THE LIFECARE INDUSTRY--1984

by Randell A. Smith and Aaron M. Rose

Introduction

This is Laventhol & Horwath's fourth annual comprehensive survey of the lifecare/continuing care retirement center industry in the United States. The continuing care concept is a viable solution to meeting the housing needs and preferences of elderly Americans who are able to afford the benefits. In exchange for the financial commitment of a one-time entry fee and monthly rent, residents in these communities are guaranteed housing for life among their peers, with appropriate on site medical and nursing facilities, while retaining their independent lifestyle. In this 1984 report, L&H continues to provide statistical information and operating data about this rapidly expanding industry.

Estimates indicate that there are more than 600 lifecare communities in the United States at the present time. For the purposes of this study, L&H used the following criteria in determining strictly those communities to be included in this analysis:

- Medical and skilled nursing care are available on the premises.
- Independent living units are provided (either apartments, rooms or cottages).
- An entry fee is required.
- A written continuing care contract is offered covering the balance of the resident's life.

Of the approximately 550 questionnaires distributed, 85 responses met our criteria and are included in this study. The sample size increased slightly for the 1984 report resulting in an expansion of the breakdowns used for analysis. This study contains information based upon:

- Facility orientation—principally lifecare; oriented toward nursing care.
- Age of apartments—built 1976 and later; built before 1976.
- Location—in a metropolitan area; outside of a metropolitan area.
- Region—Northeast; North Central; South; West.
- Size of facility—under 200 apartments; 200 apartments or more.

Comparable to last year's study, the 1984 report differentiates facilities by number of apartments per nursing care bed. The orientation of principally lifecare facilities (two or more apartments per nursing care bed) and those oriented toward nursing care (fewer than two apartments per nursing care bed) are distinct. The data for these two types of communities are displayed in separate exhibits whenever possible. Because of this new treatment, the reader should be cautious in comparing 1984 results with those presented in L&H's 1983 report.

As Exhibit 2 (page 9) shows, the average number of apartments per nursing bed was considerably higher for the principally lifecare facilities than for those oriented toward nursing care, at 4.32 apartments per bed and 0.81 apartments per bed, respectively. Thus, in this sample, the average facility oriented toward nursing care had 100.6 apartments and 123.8 beds, while those with a lifecare orientation had 258.8 apartments and only 59.9 beds.

Most of the figures used in this study are medians and upper and lower quartiles. A median is the middle figure in a column of data arranged sequentially from high to low, or low to high. The lower quartile is the dividing point between the lowest quarter and the upper three-quarters of the data group. The upper quartile is the dividing point between the highest quarter and the lower three-quarters of the data group. Thus, the lower quartile, median and upper quartile divide a series of figures into four equal parts. The results of the middle half of the facilities fall between the lower and upper quartiles.

Each line item has been analyzed separately and the medians are based on information submitted for that line item only, since not all facilities reported data for each line. The arithmetic mean was also used where appropriate. The reader is cautioned that the means and medians presented in this report are not to be considered standards for the industry, nor are they necessarily attainable or desirable goals. However, the results can be considered guidelines for comparison with the results of your own facility.

Randell A. Smith is the associate director of Laventhol & Horwath's Research and Development Division (R&D), which compiled the statistics and exhibits for this study. R&D is based in L&H's Executive Offices, Philadelphia.

Aaron M. Rose, CPA, is a partner in Laventhol & Horwath's Philadelphia office and is L&H's National Director of Retirement Centers.

Profile of participants

Exhibits 1 and 2 are profiles of the participants in this study. The following summary of characteristics for the typical principally lifecare facility provides useful background information when examining the results:

- Located in the Western United States.
- Has more than 200 apartments that were built before 1976.
- Is sponsored by a nonprofit organization.
- Provides free transportation for residents by car or bus.
- Requires a deposit of $1,000 or more to be on the waiting list.

A closer examination of Exhibit 1 reveals some interesting differences between principally lifecare facilities and those oriented toward nursing care. Very few facilities oriented toward nursing care reported having more than 200 apartment units, they were located in the North Central United States and required a deposit of less than $1,000. The apartment age category demonstrates the recent growth trend in the lifecare/continuing care retirement community industry, since principally lifecare facilities reported nearly two times as many apartments built after 1976 than primarily nursing care operations. Only eight of the principally lifecare facilities that responded to L&H's survey reported having personal care or assisted living units. This sample was not statistically significant and therefore was not analyzed.

Exhibit 1
Profile of Respondents—
Number of Respondents Within Each Category

	Number of Respondents		
	Total	Principally Lifecare	Oriented Toward Nursing Care*
Total	85	56	29
Owned by a Nonprofit Organization:			
Yes	82	53	29
No	3	3	0
Location:			
Metropolitan Area	44	28	16
Outside Metropolitan Area	41	28	13
Size of Facility:			
Under 200 Apartments	45	18	27
200 Apartments or More	40	38	2
Retain a Management Company:			
Food Service	24	19	5
Overall Management	9	6	3
Region of Country:**			
Northeast	11	9	2
North Central	27	11	14
South	26	15	11
West	23	21	2
Provide Free Transportation	64	41	23
Age of Apartments:			
Pre-1976	52	35	17
1976 and Later	33	21	12
Deposit Required for Waiting List:			
Under $1,000	37	19	18
$1,000 or More	30	24	6

*Facilities with fewer than two apartments for each nursing bed.
**Northeast—CT, DE, ME, MA, NH, NJ, NY, PA, RI, VT
North Central—IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI
South—AL, AR, DC, FL, FA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV
West—AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

Exhibit 2
Number of Apartments and Nursing Beds in Sample

	Principally Lifecare	Oriented Toward Nursing Care
Number in Sample of:		
Apartments	13,187	2,917
Nursing Beds	3,056	3,590
Average Number of Apartments for Each Nursing Bed	4.32	0.81

Acreage

Exhibit 3 presents acreage information by type of facility and location. The acreage of the site depends on proximity to a metropolitan area, which is similar to the results reported in the 1983 study. Both lifecare and nursing care facilities located outside of metropolitan areas reported considerably more acreage than facilities located in metropolitan areas.

Area of facilities

The range of apartment sizes in the principally lifecare facilities was not great. The studio/room apartment median was 395 square feet with an upper quartile of 450. The range for one-bedroom apartments was equally narrow with a 620 square foot median and a 706 square foot upper quartile. The two-bedroom units averaged 900 square feet with an upper quartile of 1,059 square feet. The full analysis of facility area is presented in Exhibit 4.

Nursing center beds

Each community is faced with the decision of how many nursing beds are necessary to satisfy the needs of the residents. Exhibit 5 presents data for the facilities according to size and age. Those communities with too few beds may have to expand their facilities to meet future demand.

Exhibit 3
Acreage—By Total and Location

	Principally Lifecare			Oriented Toward Nursing Care		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
Acreage						
Total	5.3	20.0	40.8	10.3	25.0	53.3
Location:						
Metropolitan Area	4.0	6.0	23.8	9.3	23.5	31.0
Outside of Metropolitan Area	19.3	29.0	51.5	11.8	27.0	94.8
Number of Apartment Residents Per Acre						
Total	5.9	14.6	36.0	*	*	*
Location:						
Metropolitan Area	16.9	34.5	54.3	*	*	*
Outside of Metropolitan Area	3.3	6.5	14.6	*	*	*

*Insufficient response.

Exhibit 4
Area of Apartments, Nursing Center and Activities Center (sq. ft.) Plus Selected Statistics—By Total, Size and Age of Apartments

	Principally Lifecare				
	Total			Size*	
	Lower Quartile	Median	Upper Quartile	Under 200 Apartments	200 Apartments or More
Total Area of:					
Apartment Complex	115,000	184,085	236,500	84,090	216,556
Nursing Center	13,528	20,318	36,986	10,000	22,184
Activities Center	15,250	24,093	39,393	15,358	26,653
Studio/Room	343	395	450	395	395
One-Bedroom Apartment	549	620	706	616	633
Two-Bedroom Apartment	808	900	1,059	948	888
Area of:					
Apartment Complex Per Apartment Resident	515	625	699	625	637
Activities Center Per Apartment Resident	55	100	236	144	98

*All amounts are medians.

Exhibit 5
Nursing Center Bed Analysis

	Principally Lifecare				
	Total			Size*	
	Lower Quartile	Median	Upper Quartile	Under 200 Apartments	200 Apartments or More
Number of Beds Per Community	38.0	59.0	73.0	34.0	60.0
Number of Apartments Per Bed	3.2	4.0	5.6	4.0	3.9
Number of Apartment Residents Per Bed	3.3	4.4	6.5	4.1	4.6

*All amounts are medians.

Marketing results

This year's study provides marketing information for the first time, as shown in Exhibit 6. Communities built after 1975 were asked to respond to questions about the results of their marketing efforts before beginning construction and after opening.

Exhibit 6
Pre-Sales Results and Fill-up Time For Communities Built After 1975*

Number of Months of Pre-Sales Marketing	12
Percentage of Units Reserved by Pre-Sales Marketing	50%
Percentage of Apartment Units filled during first six months	66%
Number of Months to achieve 95% occupancy	18

*All amounts are medians.

Principally Lifecare		Oriented Toward Nursing Care				
Age*		Total			Age*	
Built Pre-1976	Built 1976 and Later	Lower Quartile	Median	Upper Quartile	Built Pre-1976	Built 1976 and Later
137,649	211,022	40,516	69,225	145,752	71,000	67,450
20,318	19,696	20,060	38,448	65,094	40,000	36,700
23,444	26,653	9,475	31,000	48,388	31,000	27,978
390	410	216	356	400	320	363
639	580	543	600	779	612	599
1,005	831	823	991	1,081	1,001	939
570	699					
98	168					

Principally Lifecare		Oriented Toward Nursing Care				
Age*		Total			Age*	
Built Pre-1976	Built 1976 and Later	Lower Quartile	Median	Upper Quartile	Built Pre-1976	Built 1976 and Later
51.5	60.0	59.3	98.4	164.0	110.0	84.0
4.1	4.0	0.5	1.1	1.7	0.7	1.5
4.6	3.8	0.7	1.4	2.1	0.8	1.4

Apartment entrance fees

Exhibit 7 lists the entrance fees for both lifecare and nursing care facilities by type of apartment and for various breakdowns. The entrance fee range between the lower and upper quartile was not as broad as expected. For example, the one-bedroom fee indicated a lower quartile of $35,000, an upper quartile of $53,000 and a $44,950 median. The North Central region consistently reported the lowest entrance fee. Surprisingly, the apartment complexes built prior to 1976 were not consistently less than those built in 1976 and later, and in some cases were larger. Fees at lifecare facilities with 200 apartments or more were substantially higher than those for smaller facilities.

Exhibit 7
Apartment Entrance Fees—By Selected Criteria

	Studio/Room Fee		
	Lower Quartile	Median	Upper Quartile
Principally Lifecare			
Total	17,625	27,875	36,950
Region:			
Northeast	25,750	32,000	33,000
North Central	16,700	20,750	27,000
South	20,000	30,250	41,500
West	16,525	26,030	36,200
Location:			
Metropolitan Area	18,250	24,562	36,200
Outside Metropolitan Area	16,801	30,625	37,363
Age of Apartments:			
Built Pre-1976	16,825	23,310	36,950
Built 1976 and Later	21,675	30,250	36,948
Size:			
Under 200 Apartments	16,625	19,875	33,213
200 Apartments or More	20,225	30,250	38,875
Deposit Required:			
Under $1,000	14,700	21,000	32,000
$1,000 or More	23,355	32,500	38,750
Oriented Toward Nursing Care			
Total	6,000	18,000	27,000
Location:			
Metropolitan Area	4,313	15,000	29,153
Outside Metropolitan Area	5,250	18,350	25,625
Age of Apartments:			
Built Pre-1976	4,313	18,000	26,625
Built 1976 and Later	5,250	16,834	29,153

*Insufficient response.

One-Bedroom Fee			Two-Bedroom Fee			Three-Bedroom Fee		
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
35,000	44,950	53,000	50,238	64,000	73,875	70,363	78,000	87,250
33,500	50,000	50,750	57,750	64,000	68,500	58,750	78,000	79,000
26,896	36,000	41,500	43,475	51,254	60,665	*	*	*
36,850	51,800	65,000	50,908	72,750	79,575	76,088	91,500	105,750
33,904	45,450	53,588	47,119	65,600	77,770	*	*	*
34,250	41,084	49,375	52,319	63,950	71,500	*	*	*
36,000	48,000	60,045	46,199	64,000	77,645	70,000	79,000	90,000
32,875	45,200	54,988	45,500	64,617	78,000	60,000	77,000	89,500
36,201	44,000	52,700	50,238	58,000	72,000	70,000	78,000	90,000
27,672	39,950	47,338	42,625	55,525	64,738	55,000	71,450	77,000
36,213	48,500	60,574	52,319	66,061	78,890	71,250	79,000	92,250
31,000	38,376	47,800	42,750	51,975	64,619	63,225	75,000	94,500
42,750	50,500	60,398	64,000	72,000	78,900	70,000	79,000	90,000
16,625	29,818	41,625	25,250	40,125	54,750	*	*	*
16,625	31,000	47,637	34,000	46,300	62,897	*	*	*
14,700	23,500	36,642	21,600	37,030	51,926	*	*	*
16,500	31,000	42,000	27,250	42,000	54,000	*	*	*
8,000	23,500	44,135	10,250	38,250	60,923	*	*	*

Monthly apartment fees

In addition to the entrance fees required by each type of facility, every resident is charged a monthly apartment fee in order to defray the daily operating expenses of the respective community. Exhibit 8 lists these monthly fees by number of apartment occupants and by other selected criteria. Lifecare facilities located outside metropolitan areas reported somewhat higher monthly fees than those within metropolitan areas. Communities with 200 apartments or more have substantially higher fees than the smaller communities. With respect to facilities oriented toward nursing care, those located in metropolitan areas and the older establishments reported higher apartment fees per resident. This finding is consistent with the high entrance fees reported by these properties.

Exhibit 8
Monthly Apartment Fees
By Selected Criteria

	One Person					
	Studio/Room			One Bedroom		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
Principally Lifecare						
Total	$456	$520	$698	$472	$630	$ 877
Location:						
Metropolitan Area	391	523	652	493	623	811
Outside Metropolitan Area	480	517	781	472	630	1,029
Age of Apartments:						
Built Pre-1976	449	515	729	472	621	904
Built 1976 and Later	456	525	667	472	630	872
Size:						
Under 200 Apartments	401	464	534	457	588	675
200 Apartments or More	460	594	781	472	700	958
Meals Included in Fee:						
No Meals	283	383	401	440	458	472
1 Meal	450	530	684	530	684	840
2 or More	480	599	790	472	823	973
Oriented Toward Nursing Care						
Total	442	610	748	414	580	770
Location:						
Metropolitan Area	606	710	980	553	750	946
Outside Metropolitan Area	255	450	475	154	489	558
Age of Apartments:						
Built Pre-1976	450	633	878	471	678	934
Built 1976 and Later	$380	$570	$748	$258	$467	$ 670

One Person			Two Persons					
Two Bedrooms			One Bedroom			Two Bedrooms		
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
$504	$686	$1,051	$ 655	$ 885	$1,179	$760	$ 976	$1,435
569	687	861	646	845	1,096	757	961	1,253
499	685	1,204	683	925	1,525	805	1,091	1,620
512	589	921	646	837	1,335	757	861	1,466
504	756	1,157	705	950	1,161	815	1,091	1,422
520	583	856	646	789	945	750	845	1,008
499	748	1,111	740	1,013	1,457	810	1,112	1,512
550	570	583	618	638	646	713	756	760
713	858	1,089	767	959	1,090	954	1,142	1,356
499	795	1,115	811	1,148	1,525	845	1,353	1,613
440	620	748	589	855	1,250	665	845	1,401
489	740	1,028	1,004	1,173	1,411	814	1,220	1,598
262	525	675	233	648	844	262	678	863
250	610	725	822	1,045	1,403	370	850	1,598
$440	$690	$ 770	$ 298	$ 614	$1,008	$541	$ 705	$1,280

Nursing center rates

Exhibit 9 displays nursing center rates for private and semi-private rooms in both principally lifecare and nursing care facilities, broken down by the type of care provided. This is the first time that type of care information has been included in this study. Principally lifecare facilities reported higher rates in all categories than those reported by facilities oriented toward nursing care. The range of rates between the lower and upper quartiles underscores the large difference in facilities between various types of nursing homes.

Exhibit 9
Nursing Center Daily Rates

	Private Room			Semiprivate Room		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
Principally Lifecare						
Skilled	$62.00	$75.00	$92.00	$50.00	$59.00	$70.00
Intermediate	65.00	75.00	90.00	50.00	55.00	71.00
Personal	33.00	53.00	75.00	28.25	50.00	67.75
Oriented Toward Nursing Care						
Skilled	49.25	64.50	82.25	47.25	54.50	61.75
Intermediate	44.25	50.00	59.00	37.75	44.50	53.50
Personal	$31.50	$45.00	$70.25	$25.00	$40.00	$48.75

Rate increases

Exhibit 10 presents percentage increases in apartment and nursing center rates for the participating facilities. Rate increases are significantly smaller for 1983 than the 1982 percentage increases, 5.5 percent compared with 9.0 percent. Nursing center rates increased 7.5 percent in 1983 compared with the 9.0 percent increase in 1982.

Exhibit 10
Apartment and Nursing Center Percentage Rate Increases—1983
By Type, Age and Region

	Percentage Increase in Apartment Rates*	Percentage Increase in Nursing Center Rates*
Principally Lifecare		
Total		
1983	5.5%	7.5%
1982	9.0	9.0
Age of Apartments:		
Built Pre-1976	6.0	7.5
Built 1976 and Later	5.0	7.5
Region:		
Northeast	5.0	9.0
North Central	6.0	7.0
South	5.0	6.5
West	6.0	8.0
Oriented Toward Nursing Care		
Total		
1983	5.0	7.0
1982	8.0	10.0
Age of Apartments:		
Built Pre-1976	5.0	7.0
Built 1976 and Later	6.0%	7.5%

*All amounts are medians.

Patient days in the nursing center

Exhibit 11 provides the number of patient days spent by principally lifecare apartment residents or former apartment residents in the community nursing center. The usage by temporary patients staying in the nursing facility is approximately the same number of days per apartment resident per year in both older and newer facilities. However, as expected, the older facilities had a substantially higher ratio of permanent transfer patients.

The number of nursing beds in use in a theoretical facility with 300 residents is determined by multiplying the patient days per resident per year by the number of residents, then dividing the result by 365. In the illustration, a 300-resident principally lifecare facility built pre-1976 filled a median of 5.1 beds on a temporary basis, and 42.0 beds for permanent transfers.

Average age of residents

Exhibit 12 presents the average age of entry into lifecare or primarily nursing care facilities for male and female residents during the last three years compared with the average age of all residents in such communities in 1983. The median entry age of 77 to 79 years old has remained consistent since we began surveying the industry.

Exhibit 11
Patient Days in Nursing Center by Principally Lifecare Apartment Residents or Former Apartment Residents

	Lower Quartile	Median	Upper Quartile
Patient Days Per Apartment Resident Per Year:			
Temporary:			
Built Pre-1976	2.9	6.2	19.4
Built 1976 and Later	3.7	6.1	15.2
Permanent:			
Built Pre-1976	32.7	51.1	64.3
Built 1976 and Later	14.0	23.6	33.3
Number of Beds Occupied Per Day in Nursing Care Center for a Facility with 300 Apartment Residents:			
Temporary:			
Built Pre-1976	2.4	5.1	16.0
Built 1976 and Later	3.0	5.0	12.5
Permanent:			
Built Pre-1976	26.9	42.0	52.9
Built 1976 and Later	11.5	19.4	27.4

Exhibit 12
Average Age of Residents—By Type, Region and Age*

	Residents' Average Age at Entry to Apartments During the Last Three Years		Average Age of All Residents 1983	
	Male	Female	Male	Female
Principally Lifecare				
Total	78.0	77.0	80.5	80.0
Region:				
Northeast	78.0	79.0	79.5	81.0
North Central	76.0	74.0	81.5	80.5
South	79.0	78.0	80.5	81.0
West	76.0	75.0	81.5	82.0
Age of Apartments:				
Built Pre-1976	76.0	77.0	82.0	82.0
Built 1976 and Later	78.0	77.0	80.5	80.0
Oriented Toward Nursing Care				
Total	79.0	77.0	82.0	83.0
Age of Apartments:				
Built Pre-1976	80.0	77.0	83.0	84.0
Built 1976 and Later	78.0	77.0	82.0	83.0

*All amounts are medians.

Financial assistance plus selected information

Certain lifecare residents receive or may require financial assistance in the future. Exhibit 13 gives the percentages of residents currently requiring such assistance and provides estimates about the percentage of residents who may eventually require assistance. In addition, this exhibit presents information on the proximity of residents' families and the number of people awaiting acceptance into lifecare facilities.

Slightly less than half of the residents report having children living within a 30-minute drive of the facility. The new facilities have substantially shorter waiting lists than those built pre-1976. To illustrate, a 200-apartment lifecare facility built before 1976 and reporting a median of 0.64 persons per apartment would have 128 people on its waiting list.

Exhibit 14 reveals the median number of months a prospective resident is on a facility's waiting list. The figures indicate

Exhibit 13
Financial Assistance for Principally Lifecare Residents Plus Selected Information

	Percentage of Residents Who Currently Require Financial Assistance			Percentage of Residents Who May Eventually Require Assistance*	Percentage of Residents' Children Who Live Within 30 Minutes*	Number of Persons on Waiting List Per Apartment*
	Lower Quartile	Median	Upper Quartile			
Total	1.7%	4.2%	13.7%	5.0%	45.0%	.30
Age of Apartments:						
Built Pre-1976	1.7	4.9	15.2	6.0	40.0	.64
Built 1976 and Later	0.7%	2.7%	6.3%	5.0%	55.0%	.17

*All amounts are medians.

Exhibit 14
Principally Lifecare
Number of Months on Facility Waiting List*

	Studio/Room	One-Bedroom	Two-Bedroom
Total	12	21	24
Age of Apartments:			
Built Pre-1976	12	24	36
Built 1976 and Later	6	18	24

*All amounts are medians.

that the larger the apartment the longer the waiting time, and the pre-1976 apartments have longer waiting lists than newer facilities.

Percentage of males and females

Female longevity is well documented and is evident at the communities that participated in this study. An examination of Exhibit 15 reveals that about four out of five residents were female. The male/female ratio has been consistent in each of the four years we have produced this study.

Apartment turnover rates

Exhibit 16 presents an analysis of annual turnover rates by age of the participating lifecare facilities for the past three years. This exhibit highlights the substantially higher turnover in the older communities.

Exhibit 15
Percentage of Males and Females

	Principally Lifecare				Oriented Toward Nursing Care			
	Mean		Range		Mean		Range	
	Male	Female	Male	Female	Male	Female	Male	Female
1983	21.0%	79.0%	8.6%–35.7%	64.3%–91.4%	24.5%	75.5%	0.0%–75.0%	25.0%–100.0%
1982	20.9	79.1	8.6%–34.5%	65.5%–91.4%	23.3	76.7	0.0%–69.8%	30.2%–100.0%
1981	21.6	78.4	8.1%–35.6%	64.4%–91.9%	22.3	77.7	0.0%–75.6%	24.4%–100.0%

Exhibit 16
Apartment Annual Turnover Rates
Principally Lifecare*

	Number of Deaths Per 100 Males	Number of Permanent Transfers to Nursing Center Per 100 Males	Total Turnover Per 100 Males	Number of Deaths Per 100 Females	Number of Permanent Transfers to Nursing Center Per 100 Females	Total Turnover Per 100 Females	Total Residents Total Turnover Per 100 Residents**
Pre-1976							
1983	8.2	3.8	12.0	4.6	4.0	8.6	9.3
1982	7.4	4.5	11.9	4.3	3.8	8.1	8.9
1981	8.2	4.9	13.1	4.8	5.1	9.9	10.6
1976 and Later							
1983	4.3	2.6	6.9	3.9	2.2	6.1	6.3
1982	6.7	4.1	10.8	4.6	1.8	6.4	7.3
1981	5.9	4.0	9.9	3.2	2.9	6.1	6.9

*All amounts are medians.
**Taking into consideration previously stated proportion of females and males for each year.

Payroll and employee information

Exhibit 17 presents salary information for principally lifecare communities and for those oriented toward nursing care, and then for some selected breakdowns within each category. This information should not be compared with the data presented in last year's report because of major changes in categorizations and presentations. Expanded salary information by type of facility is presented this year. In addition to the quartiles and medians provided in past reports, the analysis includes the 10 percent and 90 percent values. This information is provided to give the reader a better idea of the range of salary data reported by the participating facilities.

The number of full-time equivalent employees in Exhibit 18 shows the broad range of numbers of employees for various departments in the facilities of different sizes and types that responded to L&H's survey. Care must be exercised in referring to this data because it does not indicate the size of the facility employing the various numbers of employees.

Exhibit 17
Payroll Information—By Selected Criteria

	Principally Lifecare								
	Total					Region*			
	10%	25%	50%	75%	90%	Northeast	North Central	South	West
Salary Per Person For:									
Executive Director or Administrator	$26,102	$30,313	$37,908	$46,875	$50,700	$35,908	$35,505	$37,242	$40,500
Assistant Executive Director	16,406	20,050	22,800	34,175	36,737	21,930	22,000	33,500	24,770
Administrative Staff (Excluding Nursing Center)	8,632	10,751	13,080	15,662	19,594	13,090	12,159	13,403	13,105
Nursing Center Administrator	19,470	21,725	24,410	29,225	33,756	21,861	24,000	25,168	24,152
Administrative Staff in Nursing Center	9,407	11,500	15,611	18,458	21,320	17,137	16,025	13,730	13,848
Nursing Staff	8,961	9,737	10,718	13,151	14,213	10,516	10,838	10,200	12,350
Dietary	6,424	7,441	8,803	10,135	11,268	7,354	8,655	8,227	10,015
Housekeeping/Laundry	7,267	8,321	9,289	10,480	11,744	9,783	8,756	8,765	9,355
Maintenance	8,823	11,020	13,772	16,914	20,216	14,297	12,764	12,330	14,111
Security	5,596	7,327	9,130	11,160	13,450	9,709	7,490	9,585	8,408
All Other	$ 7,325	$ 9,540	$12,733	$16,250	$19,805	$11,000	$12,753	$12,889	$12,558

*All amounts are medians.

Exhibit 18
Employee Information—By Selected Criteria

	Principally Lifecare					Oriented Toward Nursing Care				
	Total					Total				
	10%	25%	50%	75%	90%	10%	25%	50%	75%	90%
Number of Full-Time Equivalent Employees:										
Executive Director or Administrator	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.2
Assistant Executive Director	1.0	1.0	1.0	1.0	2.0	1.0	1.0	1.0	1.4	2.0
Administrative Staff (Excluding Nursing Center)	2.0	4.0	5.3	8.4	12.0	2.0	3.5	5.3	8.4	15.5
Nursing Center Administrator	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.4
Administrative Staff in Nursing Center	1.0	1.0	2.0	4.4	6.8	1.0	1.1	3.3	16.0	23.4
Nursing Staff	16.7	23.5	36.0	42.0	67.4	20.1	31.1	48.0	75.8	146.6
Dietary	10.4	17.0	35.5	49.5	60.9	10.5	11.9	20.0	29.8	46.2
Housekeeping/Laundry	4.0	6.1	11.0	19.8	23.3	3.5	7.3	13.8	20.8	29.1
Maintenance	2.0	3.0	6.3	10.5	14.4	2.0	2.6	5.0	7.9	13.6
Security	1.0	2.0	3.5	6.5	9.9	1.0	1.1	3.0	5.3	8.0
All Other	1.0	3.0	6.0	13.0	29.4	1.0	2.3	7.5	18.3	83.2

Principally Lifecare				Oriented Toward Nursing Care						
Size*		Location*		Total					Location*	
Under 200 Apartments	200 Apartments or More	Metropolitan Area	Outside Metropolitan Area	10%	25%	50%	75%	90%	Metropolitan Area	Outside Metropolitan Area
$31,894	$40,500	$37,534	$38,158	$23,493	$31,250	$34,500	$40,360	$46,030	$40,480	$32,709
20,430	25,920	23,960	22,800	13,633	22,005	24,150	28,090	34,800	27,650	24,012
11,000	13,105	12,588	13,090	6,982	11,240	12,335	14,717	17,330	12,335	12,370
20,250	25,084	24,000	25,084	18,959	21,287	22,101	25,000	28,313	25,000	21,794
16,911	14,096	12,636	16,717	6,559	9,568	14,676	17,624	21,716	15,043	13,551
9,737	10,768	10,465	10,728	7,601	8,018	9,526	11,764	13,031	10,644	8,326
7,620	9,126	8,385	8,882	6,092	7,279	8,854	10,282	11,139	9,299	8,481
8,328	9,313	8,901	9,333	7,072	7,846	8,433	9,368	10,396	8,560	8,432
11,282	14,315	13,692	13,818	8,077	10,532	12,271	14,600	15,935	14,099	11,565
9,000	9,261	9,261	8,969	8,408	9,743	10,379	12,125	14,000	11,252	10,374
$11,323	$12,733	$12,678	$12,742	$ 4,466	$ 7,641	$11,000	$13,333	$15,650	$12,658	$ 9,095

Payroll and employee ratios

Exhibit 19 analyzes payroll and employee statistics by various departments. Although most figures are medians, the range of responses is shown in the total information.

Exhibit 19
Payroll and Employee Statistics—By Selected Criteria

	Principally Lifecare				
	Total			Region*	
	Lower Quartile	Median	Upper Quartile	Northeast	North Central
Dietary Department					
Dietary Payroll Per Meal	$1.23	$1.43	$1.74	$1.60	$1.35
Housekeeping and Maintenance Department					
Housekeeping Payroll Per Square Foot of Entire Facility	.26	.52	.70	.30	.43
Maintenance Payroll Per Square Foot of Entire Facility	.27	.39	.54	.25	.35
Square Feet Per Housekeeper	10,168	18,105	30,844	23,500	18,359
Square Feet Per Maintenance Employee	20,947	34,648	51,875	43,777	30,846
All Departments					
Total Number of Residents and Patients Per Employee	2.1	2.7	3.4	2.4	3.1
Cost of Employee Medical Benefits Per Employee	$223	$482	$627	$222	$322

*All amounts are medians.

Principally Lifecare							
Region		Size*		Age of Apartments*		Location*	
South	West	Under 200 Apartments	200 Apartments or More	Built Pre-1976	Built 1976 and Later	Metropolitan Area	Outside Metropolitan Area
$1.36	$1.53	$1.39	$1.49	$1.43	$1.38	$1.39	$1.51
.45	.60	.42	.54	.60	.41	.52	.46
.34	.47	.31	.41	.44	.29	.37	.41
13,210	17,319	18,677	16,820	16,976	20,905	16,820	19,727
36,054	37,379	36,375	34,648	39,322	34,121	33,877	35,527
2.3	2.7	2.4	2.7	2.7	2.5	2.9	2.4
$515	$527	$368	$506	$497	$318	$490	$402

	Oriented Toward Nursing Care						
	Total			Age of Apartments*		Location*	
	Lower Quartile	Median	Upper Quartile	Built Pre-1976	Built 1976 and Later	Metropolitan Area	Outside Metropolitan Area
Dietary Department							
Dietary Payroll Per Meal	$.90	$.99	$1.10	$.98	$1.00	$.99	$.97
Housekeeping and Maintenance Department							
Housekeeping Payroll Per Square Foot of Entire Facility	.59	.91	1.39	1.06	.64	.91	.88
Maintenance Payroll Per Square Foot of Entire Facility	.34	.50	.74	.53	.41	.77	.45
Square Feet Per Housekeeper	6,266	8,889	14,604	8,419	13,120	8,779	9,953
Square Feet Per Maintenance Employee	18,156	26,371	37,336	21,760	34,732	22,342	27,415
All Departments							
Total Number of Residents and Patients Per Employee	1.5	1.7	2.1	1.7	1.8	1.8	1.7
Cost of Employee Medical Benefits Per Employee	$195	$355	$492	$346	$403	$403	$282

*All amounts are medians.

Various expense ratios

Various food, utilities and medical expense statistics are shown in Exhibit 20 by type of facility. An analysis of 1983 data as well as three-year comparison information is presented in Exhibit 21.

Loss of revenue

Exhibit 22 displays data concerning the annual loss of revenue attributable to apartment residents who became temporary or permanent residents in the facilities' nursing centers during 1983. This cost is obtained by taking the difference between nursing center standard charges for private pay patients and the amount collected from apartment or former apartment residents.

Reserve funds

Exhibit 23 illustrates the amount of reserve funds for the two types of facilities analyzed in this study. Reserve funds are an indication of the financial well-being of a community.

Exhibit 20
Various Expense Statistics—1983

	Principally Lifecare						
	Total			Region*			
	Lower Quartile	Median	Upper Quartile	Northeast	North Central	South	West
Raw Food Cost Per Meal	$1.03	$1.38	$1.59	$1.38	$ .98	$1.52	$1.38
Utilities Expense Per Square Foot	.90	1.10	1.26	1.39	1.05	1.19	.99
Cost of Food Management Service Per Meal	.10	.14	.26	**	**	.14	.10
Annual Medical Cost Per Apartment Resident	$214	$309	$492	**	**	$381	$247

*All amounts are medians.
**Insufficient response.

Exhibit 21
Various Expense Statistics—Three-Year Comparison

	Principally Lifecare			Oriented Toward Nursing Care		
	Total			Total		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
Raw Food Cost Per Meal						
1983	$1.03	$1.38	$1.59	$ .90	$1.03	$1.23
1982	1.00	1.29	1.48	.75	.90	1.24
1981	.83	1.18	1.46	.75	.92	1.12
Utilities Expense Per Square Foot						
1983	.90	1.10	1.26	1.00	1.18	1.40
1982	.87	1.04	1.30	.80	1.09	1.36
1981	$ .76	$ .88	$1.08	$ .47	$1.22	$2.11

Exhibit 22
Loss of Nursing Facility Revenue in Principally Lifecare Communities*

	1983 Loss of Revenue Per Apartment Resident	
	Permanent Transfers	Temporary Transfers
Total	$ 785	$369
Region:		
Northeast	728	877
North Central	468	280
South	640	188
West	1,805	310
Location:		
Metropolitan Area	606	329
Outside Metropolitan Area	1,025	369
Age of Apartments:		
Built Pre-1976	1,713	430
Built 1976 and Later	591	181

*All amounts are medians.

Principally Lifecare		Oriented Toward Nursery Care		
Size*		Total		
Under 200 Apartments	200 Apartments or More	Lower Quartile	Median	Upper Quartile
$1.17	$1.43	$ .90	$1.03	$1.23
1.05	1.13	1.00	1.18	1.40
**	.14	.03	.08	.16
**	$338	**	**	**

Exhibit 23
Reserve Funds

	Principally Lifecare			Oriented Toward Nursing Care		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
Total Amount of All Reserves	$304,037	$703,371	$2,045,780	$164,735	$447,864	$1,161,818
Total Reserves Per Resident	1,318	4,364	8,894	1,460	6,316	18,084

Laventhol & Horwath

Certified Public Accountants

Executive Offices: 1845 Walnut Street, Philadelphia, PA 19103
215-299-1600 Telex: 83-1396 HORWINTAS PHA

Alaska
730 I St., Suite 400
Anchorage, Alaska 99501
907-276-5811

Arizona
1314 N. Third St., Suite 100
Phoenix, Ariz. 85004
602-252-0920

5151 E. Broadway, Suite 1200
Tucson, Ariz. 85711
602-790-2255

California
695 Town Center, Suite 310
Costa Mesa, Calif. 92626
714-556-4244

3699 Wilshire Blvd.
Los Angeles, Calif. 90010
213-381-5393
Telex: 4992753 HORWINTAS LSA

Two Century Plaza, Suite 3700
2049 Century Park East
Los Angeles, Calif. 90067
213-553-1040
Telex: 696374

2570 El Camino Real, Suite 310
Mountain View, Calif. 94040
415-941-3537

101 W. Broadway, Suite 1300
San Diego, Calif. 92101
619-236-1188

50 California St., Suite 2450
San Francisco, Calif. 94111
415-989-0110

Colorado
1600 Emerson St.
Denver, Colo. 80218
303-861-2500

Connecticut
Park City Plaza
10 Middle St.
Bridgeport, Conn. 06604
203-333-5133

District of Columbia
1901 L St., N.W.
Washington, D.C. 20036
202-463-0700
Telex: 62190620 HORWINTAS

2115 E. Jefferson St.
Rockville, Md. 20852
301-468-0888

Florida
201 Alhambra Circle
Coral Gables, Fla. 33134
305-442-2000
Telex: 264822 LH MIA UR

Barnett Plaza, Suite 1010
201 S. Orange Ave.
Orlando, Fla. 32801
305-843-9240

One Tampa City Center
201 N. Franklin St., Suite 2900
Tampa, Fla. 33602
813-228-7555

Royal Trust Building, Suite 1100
1645 Palm Beach Lakes Blvd.
West Palm Beach, Fla. 33401
305-689-6600

Georgia
225 Peachtree St., N.E.
Suite 2300, South Tower
Atlanta, Ga. 30303
404-581-0100

Illinois
P.O. Box 2618
1116 W. Main St.
Carbondale, Ill. 62901
618-457-8158

300 S. Riverside Plaza
Chicago, Ill. 60606
312-648-0555

Marriott Commerce Bldg.
509 S. 6th St.
Springfield, Ill. 62701
217-544-8955

Indiana
8900 Keystone Crossing
Suite 305
Indianapolis, Ind. 46240
317-848-7133

Massachusetts
Two Center Plaza
Boston, Mass. 02108
617-742-6100
Telex: 940899 LAV HOR BSN

Michigan
26400 Lahser Rd., Suite 200
Southfield, Mich. 48034
313-354-6000

Minnesota
100 Washington Square, Suite 1650
Minneapolis, Minn. 55401
612-332-5500

Missouri
1100 CharterBank Center
920 Main St.
Kansas City, Mo. 64105
816-221-6500
Telex: 750189 LAVENTHOL UD

Ten Broadway, Suite 1000
St. Louis, Mo. 63102
314-421-1710

Nevada
Valley Bank Center, 7th Floor
101 Convention Center Dr.
Las Vegas, Nev. 89109
702-737-5533

New Jersey
Turnpike Plaza Bldg.
197 Highway 18
East Brunswick, N.J. 08816
201-257-6000

New York
445 Broad Hollow Rd.
Melville, N.Y. 11747
516-694-0530

919 Third Ave.
New York, N.Y. 10022
212-980-3100
Telex: 236501 LNH UR

1776 Broadway
New York, N.Y. 10019
212-586-6015
Telex: 640279

North Carolina
One NCNB Plaza, Suite 3420
Charlotte, N.C. 28280
704-377-0220

Ohio
National City Center
1900 E. 9th St.
Cleveland, Ohio 44114
216-696-4770

88 E. Broad St., Suite 980
Columbus, Ohio 43215
614-221-9494

1500 N. Main St.
Niles, Ohio 44446
216-369-5140

Oregon
1850 Georgia Pacific Bldg.
900 S.W. Fifth Ave.
Portland, Ore. 97204
503-221-0141

Pennsylvania
The G.S.B. Bldg.
Bala Cynwyd, Pa. 19004
215-839-4500

P.O. Box 1865
Harrisburg, Pa. 17105
717-761-7171

1845 Walnut St.
Philadelphia, Pa. 19103
215-299-1700
Telex: 83-1396 HORWINTAS PHA

15 S. Franklin St.
Wilkes-Barre, Pa. 18701
717-822-1174

Puerto Rico
1701 Banco Popular Center
Hato Rey, P.R. 00918
809-765-5580

Rhode Island
40 Westminster St.
Providence, R.I. 02903
401-421-4800

Texas
2121 San Jacinto St.,
Suite 1700
Dallas, Tex. 75201
214-754-7100
Telex: 730903 HORWINTAS DAL

333 Clay St., Suite 1100
Houston, Tex. 77002
713-658-1071

Washington
Metropolitan Park
1100 Olive Way
Seattle, Wash. 98101
206-621-1900

DIVISIONS

Valuation Counselors, Inc.
230 W. Monroe St.
Chicago, Ill. 60606
312-368-0200

2055 Craigshire Dr.,
Suite 410
St. Louis, Mo. 63146
314-576-0035

Valuation Counselors Eastern, Inc.
Princeton Pike Office Park,
CN 30
Princeton, N.J. 08540
609-896-0300

Valuation Counselors Central, Inc.
230 W. Monroe St.
Chicago, Ill. 60606
312-368-0900

Valuation Counselors Southeastern, Inc.
340 Interstate North Pkwy.,
Suite 440
Atlanta, Ga. 30339
404-955-0088

Valuation Counselors Southwestern, Inc.
2000 West Loop South,
Suite 1365
Houston, Tex. 77027
713-877-0200

Valuation Counselors Western, Inc.
2049 Century Park East,
Suite 2530
Los Angeles, Calif. 90067
213-553-1515

Valuation Counselors Property Records, Inc.
230 W. Monroe St.
Chicago, Ill. 60606
312-368-0200

General Systems Company, Inc.
83 Rt. 206, RD #3
Belle Meade, N.J. 08502
201-359-3440

HORWATH & HORWATH INTERNATIONAL
Headquarters: 919 Third Avenue, New York, NY 10022
212-980-3100 Telex: 236501 LNH UR
(Partner and correspondent firms in these countries)

Andorra
Argentina
Australia
Austria
Bahamas
Bahrain
Bhutan
Bolivia
Brazil
Cameroon
Canada
Channel Islands
Chile
Colombia
Costa Rica
Cyprus
Denmark
Dominican Republic
Ecuador
Egypt
El Salvador
Ethiopia
Finland
France
Germany
Greece
Guatemala
Haiti
Hong Kong
Iceland
India
Indonesia
Iraq
Ireland
Israel
Italy
Jamaica
Japan
Jordan
Korea
Kuwait
Lebanon
Luxembourg
Malaysia
Mexico
Monaco
Nepal
Netherlands
New Zealand
Nigeria
Norway
Oman
Panama
Peru
Portugal
Qatar
Saudi Arabia
Singapore
South Africa
Spain
Sweden
Switzerland
Syria
Taiwan
United Arab Emirates
United Kingdom
Uruguay
Venezuela
Yemen
Zimbabwe

Laventhol & Horwath

Certified Public Accountants

A Member of Horwath & Horwath International
With Affiliated Offices Worldwide